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TEMPORARY ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance
Programs

410

Agency and Division

Administrative Rules Chapter Number

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Upon filing.

Adopted on

01/01/2015 thru 06/29/2015

Effective dates

RULE CAPTION

Annual Updates for Relative Value Units, Clinical Lab and Ambulatory Surgical
Centers

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-120-1340

SUSPEND:

Stat. Auth. : ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742 &
414.743

RULE SUMMARY

The Division of Medical Assistance Programs (Division) will temporarily amend this rule to implement annual updates to the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services and Clinical Laboratory and Ambulatory surgical services.

STATEMENT OF NEED AND JUSTIFICATION

The temporary amendment of OAR 410-120-1340

In the Matter of

Federal register, Vol. 79, No.219 published November 13, 2014

<https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory>

Documents Relied Upon, and where they are available

The Division of Medical Assistance Programs (Division) General Rules, administrative rules govern payments for services provided to certain eligible clients. The Division temporarily amends OAR 410-120-1340 to implement the annual updates by the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services, Clinical Lab and Ambulatory Surgical Centers.

Need for the Temporary Rule(s)

Following the permanent rulemaking process, rather than taking this temporary rulemaking action will result in serious prejudice to the public interest and to the providers that provide services to medical assistance clients. This rule revision is needed immediately to assist the providers in applying the updated reimbursement methodologies. The authority utilizes Medicare methodologies for these programs and The Centers for Medicare and Medicaid Services (CMS) does not promulgated final regulations for these programs until November.

The Division needs to use the temporary process rather than the standard process due to time constraints. The Centers for Medicare and Medicaid Services (CMS) does not promulgated final regulations for these programs until November.

Justification of Temporary Rules



Authorized Signer

DAVID SUMMIT

Printed Name

12/23/2014

Date

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs
Agency and Division

410

Administrative Rules Chapter Number

In the Matter of: The temporary amendment of OAR 410-120-1340

Rule Caption: Annual Updates for Relative Value Units, Clinical Lab and Ambulatory Surgical Centers

Statutory Authority: ORS 413.042

Other Authority:

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742 & 414.743

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Authorized Signer

DAVID SUMMIT

Printed name

12/23/2014

Date

410-120-1340

Payment

(1) The Division of Medical Assistance Programs (Division) shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.

(2) Division reimbursement for services may be subject to review prior to reimbursement.

(3) The Division that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.

(4) The Division uses FFS payment rates in effect on the date of service that are the lesser of:

(a) The amount billed;

(b) The Division maximum allowable amount or;

(c) Reimbursement specified in the individual program provider rules.

(5) Amount billed may not exceed the provider's "usual charge" (see definitions).

(6) The Division's maximum allowable rate setting process uses the following methodology for:

(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the ~~2015~~2014 Total RVU weights published in the Federal Register, Vol. 7978, ~~November 13, 2014~~December 10, 2013 to be effective for dates of services on or after January 1, ~~2015~~2014:

(A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight;

(B) For professional services typically performed in a facility, the Facility Total RVU weight;

(C) The Division applies the following conversion factors:

(i) \$40.79 for labor and delivery codes (59400-59622);

(ii) \$36.0666 for Federally Qualified primary care codes billed by providers meeting the criteria in OAR 410-130-0005 for dates of service between January 1, 2013 and December 31, 2014;

(iii) \$27.82 for other Oregon primary care providers and services not specified in sub-paragraph (ii). A current list of primary care CPT, HCPCS₁ and provider specialty codes is available at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(iv) \$25.48 for all remaining RVU weight based CPT/HCPCS codes.

(D) Rate calculation: Effective January 1, ~~2015~~2014, the Division shall calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) $\text{Work RVU} \times (\text{Work GPCI of } .9861) + (\text{Practice Expense RVU}) \times (\text{Practice GPCI of } 0.9742) + (\text{Malpractice RVU}) \times (\text{Malpractice GPCI of } 0.708667)$;

(ii) Sum in paragraph (D)(i) multiplied by the applicable conversion factor in paragraph (C) section G.

(b) Non RVU based rates:

(A) \$20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;

(B) Clinical lab codes are priced at 70 percent of the ~~2015~~2014 Medicare clinical lab fee schedule;

(C) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80 percent of the ~~2014~~2013 Medicare fee schedule;

(D) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed, the rate shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25 percent. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Data Bank. These rates may change periodically based on drug costs;

(E) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling;

(F) Individual provider rules may specify reimbursement rates for particular services or items.

(7) The rates in section (6) are updated periodically and posted on the Authority web site at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(8) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Division's Hospital Services Program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.

(9) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services Program rules (OAR chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(10) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.

(11) The Division sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, and psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by APD for out-of-state nursing facilities.

(12) The Division may not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent, or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.

(13) The Division may not make a separate payment or copayment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services Program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services Program administrative rules (chapter 410, division 148);

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);

(c) Continuous oxygen ~~which~~ that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies pProgram administrative rules (chapter 410, division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services pProgram administrative rules (chapter 410, division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services pProgram administrative rules (chapter 410, division 130);

(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services Pprogram rules (chapter 410, division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies pProgram administrative rules (chapter 410, division 122).

(14) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in OAR chapter 410, division 142.

(15) Payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not ~~cannot~~ exceed the co-insurance and deductible amounts due;

(b) The Division pays the ~~Division~~-allowable rate for ~~Division~~-covered services that are not covered by Medicare.

(16) For clients with third-party resources (TPR), the Division pays the ~~Division~~-allowed rate less the TPR payment but not to exceed the billed amount.

(17) The Division payments, including contracted PHP or CCO payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, ~~such~~ payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(18) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042

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